IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE DIET DRUGS (Phentermine/ Fenfluramine/Dexfenfluramine) PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1203

PRETRIAL ORDER NO. 22

First Wave Discovery

This Order applies to all civil actions which are or become consolidated in MDL No. 1203, including those which are originally filed in or transferred to and docketed in the Eastern District of Pennsylvania pursuant to 28 U.S.C. §1407.

1. **Discovery Initiation Date** For purposes of this Order and for purposes of discovery in MDL 1203, the Court establishes a "discovery initiation date" ("DID") which is

(1) April 1, 1998 for those civil actions that were originally filed in or transferred to and docketed in the Eastern District of Pennsylvania before April 1, 1998 or

(2) the first day of the month following the date that a civil action is filed in or transferred to and docketed in the Eastern District of Pennsylvania to the extent that such an event occurs on or after April 1, 1998.

2. **Plaintiffs' Fact Sheets and Medical Authorizations**

(A) Within forty-five days of the DID, each plaintiff shall deliver to each defendant named in that plaintiff's complaint and to the Plaintiffs' Management Committee ("PMC") a completed Fact Sheet, copies of each document to be furnished

along with the completed Fact Sheet as specified in Part VIII of the Fact Sheet, a completed List of Medical Providers and Other Sources of Information, completed authorizations all in the forms which are attached to this Order, and a list of any medical providers as to which plaintiff objects to use of such an authorization.

(B) Prior to using any authorization furnished pursuant to the preceding paragraph in order to obtain medical records or other documents with respect to a plaintiff, the person using any such authorization shall provide the plaintiff's counsel or the plaintiff, if unrepresented, with the names of the persons to whom the authorizations will be addressed. In addition, if defendants propose to address an authorization to a medical provider or other third party not listed in a plaintiff's List of Medical Providers, plaintiff shall have ten (10) days in which to object to use of the authorization. In the event that a party has objected to the use of an authorization to obtain records from any medical providers or other third parties, the authorization shall not be used to request records from such medical provider or third party until the objection is resolved. Upon request of plaintiff's counsel, defendants' counsel shall provide copies of the records requested to plaintiff's counsel at a reasonable cost. Authorizations may not be used to obtain information other than documents and records.

(C) Plaintiffs' completion of the Fact Sheet, List of Medical Providers, and Authorizations and production of documents pursuant to this Order shall be under oath and shall be considered to be responses to interrogatories and requests for the production of documents under Rules 33 and 34 of the Federal Rules of Civil Procedure, but shall not preclude defendants from obtaining additional discovery from plaintiffs of a

non-duplicative nature. Plaintiffs' counsel reserve the right to object to defendants' future discovery requests on any proper ground.

3. **First Wave Discovery Addressed to Defendants**

(A) The PMC, on behalf of all plaintiffs, has served one set of comprehensive interrogatories and requests for production of documents on each defendant who is alleged to have manufactured, marketed or sold the diet drugs which are the subject of this litigation (other than medical providers, clinics, diet centers, and the like).

(B) Within twenty-one (21) days of the date of this Order, defendants shall serve any objections to such discovery requests.

(C) Thereafter, the parties shall meet and confer in a good faith effort to resolve Defendants' Objections to Plaintiffs' Interrogatories and Document Production Requests.

(D) A hearing is scheduled to take place before the Court on April 21st, 1998 at 11:00 a.m. in Courtroom 17B, United States Courthouse, 601 Market Street, Philadelphia, PA 19106 to resolve any objections which have been made to plaintiffs' first wave discovery requests which the parties have been unable to resolve.

(E) Within forty-five (45) days of the April 1, 1998 DID, each defendant shall answer each of the plaintiffs' interrogatories which were not subject to objection. Interrogatories to which objections are raised and overruled shall be answered at such time as shall be determined by the Court.

(F) Within thirty (30) days of the April 1, 1998 DID, each defendant shall make a substantial production to Plaintiffs' Document Depository of documents responsive to plaintiffs' Document Production Requests. Within thirty (30) days of such initial production, each defendant shall make a second substantial production of responsive documents. Within thirty (30) days of the second production, defendants shall make their final production of documents which are responsive to Plaintiffs' Document Production Requests. Fifteen days thereafter, each defendant shall provide a privilege log listing any documents withheld on a claim of attorney-client privilege and/or work product protection. For good cause shown, defendants may seek extensions of the dates in the preceding two sentences from the Court. Documents which are subject to a claim of privilege which is overruled or denied shall be produced at such time as shall be determined by the Court.

(G) Any plaintiff who wishes to serve interrogatories and document production requests on any defendant who is a medical provider, diet center, clinic, or the like, may do so at any time provided that such requests are coordinated with and through the PMC which shall assure that discovery requests directed to such defendants are not duplicative. Any defendant may likewise serve such discovery.

(H.) Defendants' Response to Plaintiffs' Interrogatories and Document Production Requests and the production of documents pursuant to the Self-Executing Disclosure Provisions of this Order shall not preclude plaintiffs from obtaining additional discovery from defendants of a non-duplicative nature. Defendants' counsel reserve the right to object to plaintiffs' future discovery requests on any proper ground.

4. **Self-Executing Disclosures**

(A) Within thirty (30) days of the April 1, 1998 DID, defendants shall provide the PMC with a copy of each and every document previously produced in any civil action involving fenfluramine, dexfenfluramine, and/or phentermine. This includes all discovery responses produced, all transcripts or records of any testimony given by way of affidavit, deposition, at a hearing or at trial, and all documents tendered for inspection and copying, which shall include all documents delivered to opposing parties in such litigation.

(B) Within thirty (30) days of the April 1, 1998 DID, defendants shall provide plaintiffs with the documents and other information described in Fed.R.Civ.P. 26(a)(1)(D).

5. **Third Party Document Production Requests**

Any party may request the production of documents by a third party through a Subpoena Duces Tecum. The party initiating such discovery shall ensure that the documents produced are given a distinct identifying number in the manner set forth in paragraph 6(C) of this Order and that a copy of all such documents are provided to Arnold Levin on behalf of plaintiffs and to Michael T. Scott for the defendants.

6. **Plaintiffs' Document Depository**

(A) The PMC is hereby authorized to establish and maintain a document depository and office at 414 Walnut Street, Philadelphia, Pennsylvania 19106.

(B) With respect to any documents which defendants are required to produce pursuant to the terms of this Order or in response to a request for production of documents, one copy of the documents shall be delivered to the PMC's document depository and shall be maintained there pending further order of the court.

(C) All documents produced by any defendant to the PMC depository shall be uniquely identified with an alpha numeric designation which shall be indelibly stamped on the documents in such a way as not to obliterate any text. This designation shall contain an alpha prefix followed by whole numbers assigned in numerical sequence for each document produced.

(D) The detailed provisions concerning the operation of, and access to, the PMC depository will be the subject of a future Order of the Court. The Court's Order will assure, inter alia, that plaintiffs' attorneys in state court actions involving fenfluramine, dexfenfluramine, and/or phentermine will be entitled to review documents

in the PMC depository at no cost to the reviewing attorney and will be able to obtain copies of such documents at a price which will not exceed the reasonable cost of reproduction, provided that such plaintiffs' counsel agree to be bound by the terms of the Confidentiality Order governing MDL Docket No. 1203 or by the terms of a Protective Order of comparable scope entered in the state court litigation.

7. **Other Discovery**

(A) Depositions may be taken in order to preserve testimony in the circumstances addressed by Fed.R.Civ.P. 27.

(B) Except as provided in this Order, no additional discovery, including depositions, shall be taken until further Order of the Court.

BY THE COURT:

DATED:

Louis C. Bechtle
Chief Judge Emeritus

COUNSEL

THIS FACT SHEET WAS TO BE ATTACHED TO PTO #22 IN MDL 1203

PLEASE ATTACH TO PTO #22

IN RE DIET DRUGS
PRODUCTS LIABILITY LITIGATION

MDL-1203

PLAINTIFF'S FACT SHEET

This Fact Sheet and the attached List of Medical Providers and Other Sources of Information must be completed by each plaintiff in MDL 1203 who used diet drugs or who is the representative of a person or the estate of a deceased person who used diet drugs.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. MDL Civil Action No.: _____

3. Court in which action originally brought (transferor district):

_____

4. Original civil action number in the transferor court.

Civil Action No.: _____

5. Please state name, address, telephone number, fax number and E-mail address of principal attorney representing you.

_____
Name

_____
Firm

_____
City, State and Zip Code

_____
Telephone number Fax number

_____
E-mail address

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. _____
Your Name

2. _____
Street Address

3. _____
City, State and Zip Code

4. In what capacity are you representing the individual:

_____

5. If you were appointed by a court, state the:

_____ _____
Court Date of Appointment

6. Your relationship to deceased or represented person:

_____

7. If you represent a decedent's estate, state the date of death of the decedent.

_____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used diet drugs. Those questions using the term "You" refer to the person who used the diet drugs. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

C. Claim Information

1. Do you claim that you have suffered a bodily injury as the result of the use of Pondimin (fenfluramine), Redux (dexfenfluramine) or phentermine?[1]

Yes _____ No _____

[1] For description of phentermine products see chart in Part VI.

2. If the answer to the foregoing questions is "Yes", state the nature of the injury or injuries which you claim.

_____

_____

_____

3. If you do not claim you have suffered a bodily injury as the result of the use of Pondimin, Redux and/or phentermine, state how you have been injured.

_____

_____

_____

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known:

_____

C. Present Street Address: _____

_____

City State Zip Code

D. Current or last employer:

_____

Name

_____

Address

_____

Dates of Employment

_____

Occupation

E. Social Security Number: _____

F. Date of Birth: _____

G. Sex: Male _____ Female _____

H. Have you ever served in any branch of the U.S. Military?

Yes _____ No _____

If yes, please state:

1. What branch and the dates of service.

_____

2. Were you discharged for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, state what that condition was.

_____

I. Have you ever been rejected from military service for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, state what that condition was.

_____

J. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Claim/docket number, if applicable _____

4. Nature of disability: _____

5. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim]

K. Have you ever filed a social security disability claim?

Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Nature of disability: _____

4. Period of disability: _____

[Attach additional sheets if necessary to describe more than one claim]

L. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

Yes _____ No _____

If so, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action or suit.

_____

_____

M. Have you been convicted of a felony within the last 10 years?

Yes _____ No _____

III. FAMILY INFORMATION

A. Are you currently married?

Yes _____ No _____

B. Has your spouse filed a loss of consortium claim?

Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. Spouse's occupation: _____

F. Has any parent, grandparent or sibling been diagnosed with heart, lung, or liver problems?

Yes _____ No _____ I Don't know _____

If yes, identify each such person below and provide the information requested.

1. Name _____

   Current Age (or Age at Death) _____

   Type of Problem _____

   If Applicable, Cause of Death _____

2. Name _____

   Current Age (or Age at Death) _____

   Type of Problem _____

   If Applicable, Cause of Death _____

3. Name _____

   Current Age (or Age at Death) _____

Type of Problem _____

If Applicable, Cause of Death _____

IV. CURRENT MEDICAL CONDITION

A. Do you currently suffer from any physical injuries, illnesses or disabilities?

Yes _____ No _____

B. If the answer is yes, please state the following:

1. Identify the injury, illness, or disability and date of onset:

_____ _____
Injury, illness or disability Date of onset

2. By whom first diagnosed:

_____ _____
Name Address (if not otherwise provided)

V. MEDICAL BACKGROUND

A. Height: _____

B. Weight before use of Pondimin, Redux or phentermine:

_____

C. Current weight: _____

D. To the best of your knowledge, have you ever used any of the following?

Substance	Date First Taken	Date Last Taken
1. Oral contraceptives		
Yes _____ No _____	___/___/___	___/___/___
2. Antidepressants		
Yes _____ No _____	___/___/___	___/___/___

	Substance	Date First Taken	Date Last Taken
3.	Heart medications Yes ____ No ____	____/__/____	____/__/____
4.	Blood pressure medication Yes ____ No ____	____/__/____	____/__/____
5.	Thyroid supplements Yes ____ No ____	____/__/____	____/__/____
6.	Diuretics Yes ____ No ____	____/__/____	____/__/____
7.	Non-prescription intravenous injections Yes ____ No ____	____/__/____	____/__/____
8.	Any use of cocaine, crack cocaine, or heroin or use of marijuana on more than 4 occasions Yes ____ No ____	____/__/____	____/__/____
9.	Amphetamines Yes ____ No ____	____/__/____	____/__/____
10.	Inhaled non-prescription substance (e.g., inhalation of glue or toluene) Yes ____ No ____	____/__/____	____/__/____
11.	Methysergide (Sansert) Yes ____ No ____	____/__/____	____/__/____
12.	Ergotamine preparations (Cafergot) Yes ____ No ____	____/__/____	____/__/____

Substance	Date First Taken	Date Last Taken
13. L-tryptophan		
Yes ____ No ____	____/__/____	____/__/____
14. Any medication for migraine headaches		
Yes ____ No ____	____/__/____	____/__/____

If yes, identify the medication _____

E. Have you used prescription medications (other than Pondimin, Redux or phentermine), herbal preparations, or over the counter products to control or reduce your weight

Yes _____ No _____

If yes, state

_____	_____
product	approx. dates of use
_____	_____
product	approx. dates of use
_____	_____
product	approx. dates of use

F. Smoking history [check whichever is applicable]

1. never smoked cigarettes _____

2. past smoker of cigarettes _____

   date on which smoking ceased _____

   amount smoked: _____ packs per day for _____ years

3. current smoker of cigarettes _____

   amount smoked: _____ packs per day for _____ years

G. Drinking history

1. Do you now or have you in the past drunk alcohol (beer, wine, whiskey, etc.)?

Yes _____ No _____

If yes, check the following box which represents your greatest alcohol consumption over an extended period.

_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 15 or more drinks per week

H. To the best of your knowledge, have you ever experienced any of the following?

1.	Shortness of breath not associated with vigorous exercise	Yes _____	No _____
2.	Persistent or recurrent pain in your chest	Yes _____	No _____
3.	Irregular heart beat, including heart palpitations, tachycardia and bradycardia	Yes _____	No _____
4.	Abnormal lack of energy	Yes _____	No _____
5.	Fainting, dizziness or lightheadedness	Yes _____	No _____
6.	Sleep apnea, other sleep breathing disorder, or difficulty breathing	Yes _____	No _____
7.	Snoring	Yes _____	No _____
8.	Head pounding	Yes _____	No _____
9.	Significant swelling of ankles other than during pregnancy	Yes _____	No _____
10.	Memory loss	Yes _____	No _____
11.	Arthritis or joint pain	Yes _____	No _____

I. If you claim psychological or emotional injury as a consequence of diet drugs, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of Pondimin, Redux or phentermine.

Yes _____ No _____

If yes, state:

1. Name and address of each person who treated you

a. _____
Name

_____
Address (if not otherwise provided)

b. _____
Name

_____
Address (if not otherwise provided)

c. _____
Name

_____
Address (if not otherwise provided)

2. Condition for which treated

_____

3. When treated

_____

J. To the best of your knowledge, have you ever been told by a doctor or any other person, that you have, may have or had any of the following:

1.	Hypertension or high blood pressure	Yes _____	No _____
2.	Heart murmur	Yes _____	No _____
3.	Heart attack	Yes _____	No _____
4.	Stroke	Yes _____	No _____
5.	Blood clot to the lung (pulmonary embolism)	Yes _____	No _____
6.	Blood clot in the leg and/or phlebitis	Yes _____	No _____
7.	Chronic lung disease	Yes _____	No _____

8.	Interstitial parasitic lung disease	Yes ____	No ____
9.	Congenital abnormality of heart	Yes ____	No ____
10.	Congenital abnormality of lungs, thorax or diaphragm	Yes ____	No ____
11.	Hypoxia	Yes ____	No ____
12.	Portal hypertension	Yes ____	No ____
13.	Pulmonary vasculitis	Yes ____	No ____
14.	Immune system disease or dysfunction (including Aids or HIV)	Yes ____	No ____
15.	Rheumatic fever	Yes ____	No ____
16.	Cirrhosis, hepatitis or other liver disease	Yes ____	No ____
17.	Alcoholism	Yes ____	No ____
18.	Carcinoid syndrome	Yes ____	No ____
19.	Other Cancer If yes, specify:_____	Yes ____	No ____
20.	Pulmonary hypertension	Yes ____	No ____
21.	Pulmonary venous hypertension	Yes ____	No ____
22.	Primary pulmonary hypertension	Yes ____	No ____
23.	Heart valve lesions	Yes ____	No ____
24.	Heart valve prolapse or regurgitation	Yes ____	No ____
25.	Neurological problem If yes, specify:_____	Yes ____	No ____
26.	Ankylosing spondylitis	Yes ____	No ____
27.	Altitude heart disease	Yes ____	No ____
28.	Cardiac arrhythmias	Yes ____	No ____
29.	Collagen vascular disease	Yes ____	No ____
30.	Endocarditis	Yes ____	No ____
31.	Eosinophilia-myalgia syndrome (EMS)	Yes ____	No ____
32.	High cholesterol	Yes ____	No ____
33.	Hypertriglyceridemia	Yes ____	No ____
34.	Increased levels of low density lipo protein cholesterol (LDL's)	Yes ____	No ____
35.	Marfan's Syndrome	Yes ____	No ____
36.	Mediastinal Fibrosis	Yes ____	No ____
37.	Mediastinal Stenosis	Yes ____	No ____
38.	Raynaud's Disease	Yes ____	No ____
39.	Anorexia	Yes ____	No ____
40.	Bulimia	Yes ____	No ____
41.	Diabetes mellitus or other form of diabetes If yes, specify the type:_____	Yes ____	No ____
42.	Hypoglycemia (low blood sugar)	Yes ____	No ____

43.	Gall bladder disease	Yes _____	No _____
44.	Kidney disease	Yes _____	No _____
45.	Dermatomyositis	Yes _____	No _____
46.	Lupus	Yes _____	No _____
47.	Rheumatoid Arthritis	Yes _____	No _____
48.	Connective Tissue Disease	Yes _____	No _____
49.	Scleroderma	Yes _____	No _____
50.	Other autoimmune disease	Yes _____	No _____
	If yes, specify: _____		
	_____		
51.	Scarlet fever	Yes _____	No _____
52.	Sickle Cell Anemia	Yes _____	No _____
53.	Syphilis	Yes _____	No _____
54.	Thyroid disorder	Yes _____	No _____
55.	Non Malignant Tumors	Yes _____	No _____
56.	Asthma or emphysema	Yes _____	No _____
57.	Coronary artery disease	Yes _____	No _____
58.	Other heart or lung disease	Yes _____	No _____
59.	Gum disease	Yes _____	No _____

K. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other person and, if not provided in the accompanying list, the address of the physician who made the diagnosis or informed you of the condition.

1. Condition: _____

   Onset: _____

   Name and address of diagnosing physician or other person:

   _____

2. Condition: _____

   Onset: _____

   Name and address of diagnosing physician or other person:

   _____

3. Condition: _____

   Onset: _____

Name and address of diagnosing physician or other person:

_____

4. Condition: _____

Onset: _____

Name and address of diagnosing physician or other person:

_____

L. Please indicate whether you have received any of the following treatments:

1. Heart, lung or other chest surgery Yes _____ No _____

For what condition?

_____

When? _____

Treating physician:

_____

2. Treatment for heart attack or angina Yes _____ No _____

For what problem?

_____

When? _____

Treating physician:

_____

3. Pacemaker Yes _____ No _____

When? _____

Treating physician:

_____

4. By-pass surgery Yes _____ No _____

When? _____

Treating physician:

_____

M. Have you ever received any traumatic injury to your chest?

Yes _____ No _____

If yes, state when and describe the injury.

_____ _____
Injury When

N. To the best of your knowledge, state whether any of the following tests were administered BEFORE your use of Pondimin, Redux and/or phentermine.

1.	Echocardiogram	Yes _____	No _____
2.	Electrocardiogram	Yes _____	No _____
3.	Cardiac or pulmonary artery catheterization	Yes _____	No _____
4.	Pulmonary function test	Yes _____	No _____
5.	Perfusion lung scan	Yes _____	No _____
6.	Chest x-ray	Yes _____	No _____
7.	Arterial, cardiac or pulmonary angiogram	Yes _____	No _____
8.	Cardio-pulmonary or thallium stress test	Yes _____	No _____
9.	Other diagnostic test or imaging of the heart, lungs, or pulmonary arteries or arterial pressure	Yes _____	No _____

O. For each test for which you answered yes, identify the treating physician and approximate date of the test.

_____ _____
Treating Physician Approximate date

P. If an echocardiogram was taken BEFORE your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test report:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation	_____	_____	_____	_____	_____
Tricuspid Valve Regurgitation	_____	_____	_____	_____	_____
Aortic Valve Regurgitation	_____	_____	_____	_____	_____
Pulmonary Valve Regurgitation	_____	_____	_____	_____	_____

Q. To the best of your knowledge, state which of the following tests was administered **AFTER** your use of Pondimin, Redux or phentermine.

1.	Echocardiogram	Yes _____	No _____
2.	Electrocardiogram	Yes _____	No _____
3.	Cardiac or pulmonary artery catheterization	Yes _____	No _____
4.	Pulmonary function test	Yes _____	No _____
5.	Perfusion lung scan	Yes _____	No _____
6.	Chest x-ray	Yes _____	No _____
7.	Arterial, cardiac or pulmonary angiogram	Yes _____	No _____
8.	Cardio-pulmonary or thallium stress test	Yes _____	No _____
9.	Other diagnostic test or imaging of the heart, lungs, or pulmonary arteries or arterial pressure	Yes _____	No _____

R. For each test for which you answered yes, identify the treating physician and approximate date on which the tests were done.

_____ _____

Treating Physician Approximate date

S. If an echocardiogram was taken **AFTER** your use of Pondimin, Redux and/or phentermine, complete the following chart as to the results or attach a copy of the test results:

	None	Trace	Mild	Moderate	Severe
Mitral Valve Regurgitation	___	___	___	___	___
Tricuspid Valve Regurgitation	___	___	___	___	___
Aortic Valve Regurgitation	___	___	___	___	___
Pulmonary Valve Regurgitation	___	___	___	___	___

VI. DIET DRUG USE

A. Please complete the following chart with respect to each diet medication you have taken: [if you took more than one type of phentermine product, please complete this chart, including a description, for each separate phentermine product].

Drug Name: Generic/Brand	Description: Color/Shape/Writing/Name	Approximate Date First Taken	Approximate Date Last Taken	Prescribed/Dispensed by:(Doctor or Clinic)
dexfenfluramine/ Redux	15 mg. capsule: white cap with black stripe; "REDUX"			
fenfluramine/Pondimin	orange round tablet; 20 mg.			
phentermine				
phentermine				
phentermine				

B. If you took phentermine, please state the brand name(s) and manufacturer/distributor of the phentermine product(s) you took, to the extent known to you.

1. Brand Name:_____

   Manufacturer/Distributor_____

2. Brand Name:_____

   Manufacturer/Distributor_____

C. If you took phentermine, please check the description of each phentermine product which you took.

1. white capsule with blue cap; "Adipex-P" - "37.5" on cap and two dark stripes on body _____
2. white caplet with blue spots; 37.5 mg.; "LEMMON" - "99" with center score _____
3. Peanut shaped, green tablet imprinted with "S" on both sides; 37.5 mg. _____
4. 30 mg.; blue and clear capsule with blue and white beads; imprinted with "BMP 147," "Fastin" and/or "Beecham" _____
5. white tablet with blue dots; oval; 37.5 mg. _____
6. green round tablet; 8 mg. _____
7. orange round tablet; 8 mg. _____
8. yellow oblong tablet; 37.5 mg. _____
9. black-yellow capsule; 37.5 mg. _____
10. black-black capsule; 37.5 mg. _____
11. brown-clear capsule; 37.5 mg. _____
12. green-clear capsule; 37.5 mg. _____
13. red-black capsule; 37.5 mg. _____
14. yellow-yellow capsule; 37.5 _____
15. yellow-yellow capsule; 30 mg. _____
16. green-clear capsule; 30 mg. _____
17. brown-clear capsule; 30 mg. _____
18. black-black capsule; 30 mg. _____
19. blue-clear capsule; 30 mg. _____
20. gray-yellow capsule; 15 mg. _____
21. yellow-gray capsule; 18.75 mg. imprinted "18.75" _____
22. yellow-gray capsule; 15 mg.; imprinted "E882" _____
23. yellow-yellow capsule; 30 mg.; imprinted "E647" _____
24. blue-white gel capsule; "E5000"; 30 mg. _____
25. 37.5 mg. tablet with blue dots _____

26. Resin; yellow-yellow capsule imprinted with "IONAMIN 30" _____

27. Resin; yellow-gray capsule imprinted with "IONAMIN 15" _____

28. Hard yellow gel capsule; 30 mg.; "RPC-69" _____

29. green-clear gel capsule; 37.5 mg.; imprinted "ABANA" and "217" _____

30. black capsule _____

31. yellow capsule _____

32. yellow-gray capsule _____

33. blue-clear capsule _____

34. black gel capsule; 30 mg.; imprinted "Zantryl" _____

35. Other:

Please describe:_____
_____
_____

36. I can't remember what the product looked like _____

D. For each diet drug used by you, set forth the approximate date of any product change or any change or interruption in dosage.

Product	Dosage Change/Interruption/ Product Change	Approximate Date
Product	Dosage Change/Interruption/ Product Change	Approximate Date
Product	Dosage Change/Interruption/ Product Change	Approximate Date

E. Did you lose weight while on Pondimin, Redux or Phentermine?

_____Yes _____No

If the answer is yes, state the amount of weight you lost _____ and state the period during which the weight loss was achieved_____.

F. State your high and low weight over the past ten years.

High_____lbs. Approximate Date_____

Low_____lbs. Approximate Date_____

VII. INJURY CLAIMS

A. 1. Have you had discussions with any doctor about whether your condition is related to the use of diet drugs?

Yes _____ No _____ Don't know _____

2. If yes, check one of the following:

a. I was told my condition is related to the use of diet drugs _____.

b. I was told my condition is not related to the use of diet drugs _____.

c. I was told my condition may be related to the use of diet drugs _____.

d. I was told by the doctor that he does not know whether my condition is related to the use of diet drugs _____.

e. I don't recall what I was told _____.

3. Identify the doctor or doctors

_____
Name

_____
Address (if not otherwise provided)

4. If discussed with more than one doctor, please copy and complete Parts 2 and 3 for each.

B. State whether you requested that any doctor or clinic provide you with diet drugs, and, if yes, identify the drug requested.

Yes _____ No _____

If yes, identify the drug requested _____

C. Were you given any written instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the written instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

_____
Approximate date

_____
Name of person or entity (and address if not otherwise provided)

D. Were you given any oral instructions or warnings regarding the use of Pondimin, Redux and/or phentermine?

Yes _____ No _____

If yes, state when the written instructions or warnings were given and identify each person or entity from whom you received the warnings or instructions.

_____
Approximate date

_____
Name of person or entity (and address if not otherwise provided)

E. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your use of diet drugs:

1. Complete the following information with respect to your employment

for the past ten years.

Employers for Past Ten Years	Address	Type of Business/Position	Dates of Employment

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of diet drugs and the amount of income which you lost.

_____

_____

3. State your earned income for each of the last five years.

Year Income

_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____

F. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of diet drugs and for which you seek recovery in the action which you have filed?

Yes _____ No _____

If yes, state the total amount of such expenses at this time. $_____

VIII. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

A. A copy of all prescriptions for diet medications, exemplars of any unused diet medications you received as a result of such prescriptions, receipts, physician or office records, drug containers, packaging and other records which show each diet drug you have taken, the period during which you have taken each, the dosage of each diet drug and the frequency with which you took each drug.

B. A copy of all medical records from any physician, hospital or health care provider, who treated you for any disease, condition or symptom referred to in your response to questions in Part V.

C. To the extent not included in the foregoing, all records relating to any examination by a physician or other health care provider, conducted for any purpose, other than psychiatric or psychological evaluation, in the period beginning five (5) years prior to the date upon which you first used phentermine, Pondimin or Redux and continuing to date.

D. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

E. All diagnostic tests or test results including reports of echocardiograms.

F. Copies of all documents from physicians, health or weight loss clinics or others relating to the use of diet drugs, or to any condition you claim is related to the use of diet drugs.

G. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, height and weight charts, pharmacy handouts or other materials distributed with or provided to you when your prescriptions for diet medications were filled.

H. All documents in the nature of records regarding weight gain and weight loss such as charts recording weight loss, diaries of weight loss efforts, notes or descriptions of medicines or other substances used to control or reduce your weight, and the like.

I. Copies of all advertisements or promotions for diet drugs.

J. **TEN ORIGINAL SIGNED** authorizations for the release of records in the form appended hereto.

K. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the last five (5) years.

L. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

DECLARATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in part VII of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

_____ _____

Signature Date

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IN RE DIET DRUGS
(PHENTERMINE/ FENFLURAMINE/DEXFENFLURAMINE)
PRODUCTS LIABILITY LITIGATION
MDL 1203

LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IN MDL 1203 WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

A. **Your current family physician:**

_____
Name

_____
Street Address

_____
City, State, Zip Code

B. To the best of your ability, identify each of your primary care physicians for the last twenty years.

1.

_____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

2.

_____ _____
Name Approximate dates

_____
Last known address

_____
City, State, Zip Code

3.

Name _____ Approximate dates _____

Last known address _____

City, State, Zip Code _____

4.

Name _____ Approximate dates _____

Last known address _____

City, State, Zip Code _____

C. Each **cardiologist, pulmonary physician** and/or **heart, lung or chest surgeon** who has ever seen or treated you.

1.

Name _____

Specialty _____

Street Address _____

City, State, Zip Code _____

2.

Name _____

Specialty _____

Street Address _____

City, State, Zip Code _____

3.

Name _____

Specialty _____

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

D. Each **hospital** where you have received **inpatient** treatment during the last ten years.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

E. Each **hospital or healthcare facility** where you have received **outpatient** treatment (including treatment in an emergency room) during the last ten years.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

5.

Name

Specialty

Street Address

City, State, Zip Code

F. Each other **physician or healthcare provider** from whom you have received treatment in the last ten years with the exception of psychiatrists or psychologists.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

5.

Name

Specialty

Street Address

City, State, Zip Code

6.

Name

Specialty

Street Address

City, State, Zip Code

7.

Name

Specialty

Street Address

City, State, Zip Code

8.

Name

Specialty

Street Address

City, State, Zip Code

9.

Name

Specialty

Street Address

City, State, Zip Code

10.

Name

Specialty

Street Address

City, State, Zip Code

G. Each **pharmacy, drugstore** and the like where you have had prescriptions filled during the past ten years or from which you have ever received any prescription medication taken to control or reduce your weight:

1.

Name

Street Address

City, State, Zip Code

2.

Name

Street Address

City, State, Zip Code

3.

Name

Street Address

City, State, Zip Code

4.

Name

Street Address

City, State, Zip Code

5.

Name

Street Address

City, State, Zip Code

H. **If but only if** you claim that you suffered neurotoxic, psychological or emotional injuries as a result of taking diet drugs, list each **psychiatrist, psychologist and/or social worker** from whom you have received treatment during the last ten years

1.

Name

Street Address

City, State, Zip Code

2.

Name

Street Address

City, State, Zip Code

3.

_____
Name

_____
Street Address

_____
City, State, Zip Code

I. If you have submitted a claim **for social security disability benefits** in the last ten years, state the name and address of the office which is most likely to have records concerning your claim.

_____
Name

_____
Street Address

_____
City, State, Zip Code

J. If you have submitted a claim for **workers compensation**, state the name and address of the office which is most likely to have records concerning your claim.

_____
Name

_____
Street Address

_____
City, State, Zip Code

[ATTACH ADDITIONAL SHEETS, IF NECESSARY, TO COMPLETE EACH SUBSECTION]

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE DIET DRUGS (Phentermine/ Fenfluramine/Dexfenfluramine) PRODUCTS LIABILITY LITIGATION : MDL Docket No. 1203

AUTHORIZATION

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all medical records, reports, radiographic films, prescription records, echocardiographic recordings, written statements, employment records, wage records, disability records, medical bills, and other documents in your possession concerning _____

_____
Name of Patient

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who has agreed to pay reasonable charges made by you to supply copies of such records.

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgment at the bottom of this authorization.

Date: _____ _____
Patient or Guardian Signature

Date: _____ _____
Witness Signature

ACKNOWLEDGMENT

The undersigned, as the record requestor named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746 the attorney for the patient named in the foregoing medical authorization has been given fifteen (15) days advance notice that the authorization will be used to request records from the person or entity to whom it is addressed and has been afforded an opportunity to object to the request and to order copies of the records requested from the undersigned requestor at a reasonable cost.

_____

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